



Missoula City-County Health Department
Multiple Source Bacterial Analysis Form

Phone: 258-4755

****PLEASE FILL BOTTLES TO 100 ML LINE****

Supply Name: _____ Source Address: _____

Mailing Address: _____ City/State: _____ Zip: _____

PWSID #: _____ Collection Date: ___/___/___ Collected by: _____

Contact Phone: (____) _____ - _____ County: _____

PWS Only: Transported by: _____ Conditions _____
(cooler, on ice, ambient, etc.)

Type of Analysis Requested:

- _____ Total Coliform- Presence/Absence (standard test for drinking water) (\$15.00)
_____ Quanti-Tray MPN presence/absence with a colony count (\$18.00)
_____ Heterotrophic Membrane Filter (arrangements required)

Send Additional Report To:

LAB USE ONLY

Table with 9 columns: Water Source Location, Type, Collection Time, Disinfectant Residual, Sample #, Method, Result, P/A, EC. Multiple empty rows for data entry.

LAB USE ONLY

Notification: _____ DEQ _____ Owner/Operator

Test Date & Time: _____ Notification Date & Time: _____

_____ Paid _____ NC _____ PB

TYPES: R - routine; C - check/repeat; F - Follow-up, S - special

METHODS: P/A - Presence/Absence for Total Coliform; HPC - heterotrophic plate count; QT - Quanti-Tray MPN